Everett Public Schools
Health Services

Seizure History Questionnaire

Student Name: _____ Date of Birth: _____
School: _____ School Year: _____
Student Number: _____ Grade: _____
Parent/Guardian: _____ Phone: _____
Health Care Provider: _____ Phone: _____Fax_____

Date/age of first seizure: _____ Date/age of last seizure: _____

List any medications he/she is taking (include dosage/time given): _____
_____
Does the student know when he/she is about to have a seizure? _____
If so, please describe_____
How long do his/her seizures last? _____
Has the student ever had one or more seizures immediately following the first seizure? _____
Has student ever had more than one seizure in a day? _____ If so how many? _____
What type of seizures does the student have? ___Simple Partial (Sensory)
___Complex (Psychomotor/Temporal lobe)___Atonic Seizures (Drop Attacks)___Myocolonic
___Infantile Spasm___Generalized Tonic-Clonic (Grand Mal)___Absence (Petit Mal)
___Simple Partial (Jacksonian)___Other_____
Describe their seizures? _____
_____
Has the student ever had difficulty breathing during the seizure? _____
Has the color of the students' lips or nail beds ever changed during a seizure? _____
Will you be providing a change of clothes for the Health Room? _____
How long should they rest after a seizure? _____
Do you want to pick the student up after a seizure? _____

Disaster Preparation:
___I will provide 72 hours of medication in the event of a disaster (must have signed Health Care Provider orders)

Any other concerns that school administrators or RNs should be aware of that may impact your child's educational program or school experience and would be important information in the event of an accident, injury or illness at school? _____
_____
_____
_____
_____

Parent/Guardian Signature_____ Date_____

Nurses Notes:
_____
_____
_____
_____
_____